Application for the Nebraska Equipment Distribution Program

A. APPLICANT INFORMATION

(Please Print)

NAME:_____
(Last) *(First)* *(Middle Initial)*

HOME ADDRESS:_____
(Number and Street Name, or PO Box) *(Apt #)*

CITY: _____ **STATE:** _____ **ZIP:** _____ **COUNTY:** _____

DAYTIME PHONE: ( )_____ **V/TTY/Both** *(Circle One)* **HOME PHONE:** ( )_____**V/TTY/Both** *(Circle One)*

SOCIAL SECURITY NUMBER: _____-_____-_____ **BIRTH DATE:** _____/_____/_____
(Mo) *(Day)* *(Yr.)*

Name of someone who can help us contact you: (a person not living with you). NOTE: If mail address is different than the applicant's address, complete this section and check this box ❑.

NAME: _____ **TELEPHONE:** ( ) _____ **V/TTY/Both** *(Circle One)*

ADDRESS: _____**CITY:** _____ **STATE:** _____ **ZIP:**_____

B. EQUIPMENT NEEDS

Part 1 – Telephone Equipment - (Please Check Only One)

- ❑ **CapTel (Captioned Telephone)**
- ❑ **Computer Conversion Package (TTY modem only)**
- ❑ **Phone with Amplification (Built-in)**
- ❑ **Phone Amplifier**
- ❑ **TTY/TT (with 6 rolls of paper maximum)**
- ❑ **Voice Carry Over (VCO) Phone**
- ❑ **Other (please specify)**_____

Additional application required:
- ❑ **Large Visual Display**
- ❑ **Tactile Ring Signaler**
- ❑ **Telebrailler**

Check if Setup is required: ❑

Part 2 – Phone Signaling Devices – (Please Check Only One)

- ❑ **Light Signaler Phone Ring - Master**
  _____ Number of remote receivers needed (Limit of 2)
- ❑ **Phone Ringer**
- ❑ **Personal Vibrator**
- ❑ **Other (What Kind –example,"Alertmaster")**_____

C. ELIGIBILITY

Yes	No	
❑	❑	I have a hearing, visual and hearing loss, or speech disability, which prevents me from using the telephone effectively.
❑	❑	I am three years of age or older, and can demonstrate the ability to use the equipment.
❑	❑	I now have phone service or have applied for phone service in the state of Nebraska at my place of residence.
❑	❑	I am a current resident of the state of Nebraska.
❑	❑	Have you ever applied for this program? If yes, approximate month and year _____/_____

The above facts are true and complete to the best of my knowledge.

X_____DATE_____

(Applicant or Guardian's Signature if applicant is under 18 years of age)

PROFESSIONAL CERTIFICATION

(to be completed by certifier)

I certify this applicant as one of the following:

❑ Deaf ❑ Hard of Hearing ❑ Speech Disability ❑ Deaf-Blind

(check one of the following and provide appropriate information)

- ❑ Assistive Technology Project Representative (ATP)
- ❑ Audiologist or Licensed Hearing Aid Dispenser
- ❑ Augmentative Speech Pathologist
- ❑ Center for Independent Living Representative
- ❑ Licensed Physician/Assistant
- ❑ Nebraska Commission for the Deaf and Hard of Hearing (NCDHH)
- ❑ Services for the Visually Impaired Representative (SVI)
- ❑ Speech Pathologist
- ❑ Vocational Rehabilitation Representative (VR)
- ❑ Other _____

This individual requires other adaptive equipment (specify): _____

(Please Print)

NAME: _____

AGENCY NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE: ( ) _____ **FAX:** ( ) _____

E-MAIL ADDRESS: _____

X_____ **DATE:** _____

(Certifier's Signature) *(Title)*

INTERNAL USE ONLY

Approved ❑ Denied ❑

COMPLETED BY: *(Please Print)*

NAME: _____ **AGENCY:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: ( ) _____

E-MAIL ADDRESS:_____

X _____ **DATE:** _____

(NEDP Coordinator's Signature)